STATE OF LOUISIANA DHH-OPH-NUTRITION SERVICES VENDOR MANAGEMENT UNIT COMPLAINT FORM (504) 568 -8229

Complaint Against:	Vendor	Participant	Both
Date of Report//	e of Report/ Name of Clinic		
Name of Complainant			
Title of Complainant		Phone # of Con	nplainant ()
Date of Incident//		Time AM or PM	
Previous Complaint:	Yes	No	Unknown
COMPLAINT AGAINST VENDOR			
Vendor Number		Vendor Name	
CORRECTIVE ACTION TAKEN:	Phone call made		nt Visit was made
COMPLAINT AGAINST PARTICIP			
PHAME ID _		Family ID	
FI Number _		Site Number	Valid Period
NATURE OF COMPLAINT:			
CODDECTIVE ACTION TAKEN			
CORRECTIVE ACTION TAKEN:			